



ANESTHESIA HISTORY



Elliott V. Miller, M.D. [retired Anesthesiologist, Massachusetts General Hospital] addressing a group of visiting residents from Brigham and Women's Hospital at the Ether Dome in 2008.

EXPERIENCING ANESTHESIA HISTORY IN MASSACHUSETTS

Ryan LeVasseur, M.D. and Sukumar P. Desai, M.D.

Boston shares anesthesia heritage rights with Jefferson, Georgia, and Hartford, Connecticut. Elliott V. Miller, M.D. began tours of Mount Auburn Cemetery about 30-years ago for generations of anesthesia residents from the Massachusetts General Hospital [MGH]. Fifteen years ago, he also began tours at the venerable Ether Dome. We describe five sites within Massachusetts that may be visited by history enthusiasts. Beyond the scope of this article are two important sites in Hartford, Connecticut - Horace Wells' statue in Bushnell Park and his grave in Cedar Hill Cemetery.

The Ether Dome: Located in the Bullfinch building at MGH in Boston, this site is preserved in near original condition, and has been designated a National Historic Landmark. It is here that William Thomas Green Morton first publicly demonstrated the use of ether as an anesthetic on October 16, 1846 while surgeon, John Collins Warren, founder of the hospital as well as Chief of Surgery, performed a brief 7 minute procedure on Edward Gilbert Abbott. This blessing of painless surgery is considered by many to be one of the greatest medical advances ever. Thus, anesthesiologists visiting the Ether Dome tread on holy ground as they move about the small amphitheater viewing the many artifacts still preserved. Padihershef, a

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REPORT OF COUNSEL

HEALTH CARE PAYMENT REFORM HAS MOVED TO THE TOP OF THE POLITICAL AGENDA

by Edward J. Brennan, Jr.

Health care payment reform has moved to the top of the political agenda on Beacon Hill, as Governor Patrick begins his second term and a new Legislature convenes.

The Governor began the process by submitting to the Legislature his long awaited proposal to reform the system of health care payment in Massachusetts (H. 1849). House and Senate leaders have indicated that the 52 page bill is just the beginning of what will likely be a long and controversial effort to legislate con-

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EDITOR'S REPORT**A NOTE FROM YOUR EDITOR, RICHARD D. URMAN, M.D., MBA**

Welcome to another edition of the MSA Record! You will find a lot of useful information to keep you informed of what is happening in the world of anesthesia – both in Massachusetts and nationally.

As always, this edition highlights recent events and activities of a very busy year! As you will see, MSA has been active on the political, membership, and educational fronts as highlighted in the MSA President, ASA Director, Legal Counsel, and Committee reports. Topics of interest to our members include prescription authority for CRNAs, proposal for global payment systems in MA, proposed changes to the MSA bylaws, a note about ASA-PAC, reimbursement for labor epidurals, and the Anesthesia Quality Institute update. In addition, read about past and future educational opportunities, a report of our very active resident (COR) component, and tips for saving for your retirement. As usual, we highlight a local anesthesia practice, and



*Richard D. Urman, MD, MBA
Chair, Publications Committee
(2009-2012)*

we have selected Tufts Medical Center for this edition. Our feature article gives an excellent overview of anesthesia history in Massachusetts, and should be of interest to every MSA member.

We have further developed our website (www.massanesthesiology.org)

to better serve the needs of our members. Visit it often for meeting and educational updates.

Soon we will be welcoming our new MSA president, Dr. Ruben J. Azocar, as well as the newly elected Executive Committee and ASA Delegation. I hope that this edition will highlight ample opportunities to participate and inspire you to become more involved with the MSA, ASA, and their respective PACs. We have listed all current officers and committee members, so feel free to contact any of them with questions.

Finally, please mark your calendars so that you can participate in many exciting upcoming events including CME courses, MSA Annual Meeting, ASA Legislative Conference, and our regular MSA Executive Committee meetings to which all members are invited.

I hope that you enjoy reading this edition of the MSA Anesthesia Record. If you have any comments or interested in contributing an article, please contact me. ~

SAVE THE DATE

MSA Annual Meeting
Thursday Evening, May 26, 2011
Woodland Golf Club, 1897 Washington Street, Auburndale, MA

ASA Guest Speaker
Jerry A. Cohen, M.D., ASA President-Elect

6:00 - 7:00 pm	Cocktails - in the Foyer
7:00 - 8:00 pm	Dinner (surf & turf)
8:00 - 8:50 pm	ASA Update - Dr. Cohen
8:50 - 9:30 pm	MSA Business Meeting

Following Dr. Cohen's talk there will be a brief MSA Business Meeting and installation of new officers
(all MSA Members are invited and encouraged to attend)

For further information, please contact the MSA office (781-834-9174) • Email MSABOX@verizon.net

PRESIDENT'S REPORT

2011 IS A YEAR OF TRANSITION

Being the point between the first and second decades of the twenty first century, I thought it a great opportunity to highlight some of the Massachusetts Society of Anesthesiologist's (MSA) recent advances and some of the challenges we face in the future.

Looking back:

1- This past year MSA leaders met with members of our congressional delegation and successfully urged them to vote to **overturn the scheduled SGR cuts for Medicare**. We are relieved that Congress and President Obama have agreed to a 12 month SGR fix that averts a 25% Medicare payment cut.

2- We worked **successfully to achieve the law that restored full Medicare payment to anesthesiologist teaching programs that was implemented this year**, which will help sustain our academic anesthesia programs for future generations of anesthesiologists.

3- We continue to oppose independent practice for nurse anesthetists. In the past few years we have fought their attempt to win independent prescription authority. This year the MSA leadership worked with legislators **to allow prescription authority for CRNAs, but only under the supervision of a physician**, and pursuant to regulations developed jointly by the Nursing Board and the Board of Registration in Medicine. Moreover, the prescriptive authority is limited to the immediate perioperative care of a patient. CRNAs have no prescriptive powers in pre-operative and pain clinics.

Looking ahead:

1- This is a critical time for our specialty, as **healthcare reform is implemented nationally and payment reform becomes a priority** for state policy makers here in Massachusetts. We are fortunate



*Fred E. Shapiro D.O.
MSA President, 2010-2011*

that your MSA and ASA are well positioned to represent your interests in the changing healthcare arena.

2- The future for medical practice in Massachusetts will be challenging. **The state is developing legislation which could replace the current fee-for-service payment system for all providers with a global payment system based on the development of integrated provider networks, such as Accountable Care Organizations (ACOs)**. Your MSA is joining the debate and will represent our specialty and the patients we serve to ensure that the safe administration of anesthesia by anesthesiologists, either individually or through the care team model, continues to be vibrant and accessible to the citizens of Massachusetts.

See the report of our legal counsel on page one for more information.

What the MSA can do for you?

Member services continue to be our focus, and advocacy on your behalf with government, payers and other health care stakeholders is a priority.

Society leadership is working to **streamline our office and administrative services** to better carry forward our mission **in a cost effective manner**.

The **MSA website (www.MassAnesthesiology.org) is being revitalized** to be informative and easily accessible for our membership

We have developed a variety of terrific **educational CME Programs** which have been met with overwhelming success. Last year we held programs on practice management, sedation and analgesia, ultrasound guided regional anesthesia, and the New England Anesthesia Resident Education conference. **For 2011, we've introduced our first MSA winter conference Jan 13-17, in San Juan, Puerto Rico, a difficult airway symposium in March held at UMass Medical Center, and the New England Resident Educational conference sponsored this year by Beth Israel Deaconess Medical Center (BIDMC). Our Annual Meeting will be held on Thursday May 26, 2011 at The Woodland Golf Club in Auburndale, MA.** (for information: www.MassAnesthesiology.org) We hope that you will join us.

In order to ensure that the message and concerns of anesthesiologists are heard loudly and effectively in the health care arena, we urge you to consider the value of MSA and renew your membership as soon as possible. MSA leadership can be most successful **with your strong support and commitment to advocate for our specialty**, especially at this critical stage of healthcare reform

We welcome your input and suggestions. If you are interested in becoming more involved in MSA activities or require additional information, please do not hesitate to contact me at fshapiro@bidmc.harvard.edu. ~

PERSONALITY PROFILE**RUBEN J. AZOCAR, M.D., PRESIDENT - ELECT OF THE MSA**

Dr. Ruben J. Azocar was born and raised in Venezuela and graduated from the Universidad Central de Venezuela in Caracas. He continued his medical education at the University of Miami/Jackson Memorial Hospital and at Cook County Hospital in Chicago, where he completed an internship in General Surgery and a Surgical Critical Care Fellowship, respectively. Dr. Azocar trained in anesthesiology at Boston Medical Center (Boston University School of Medicine) and completed a Critical Care Fellowship at Beth Israel Deaconess Medical Center (Harvard Medical School).

Dr. Azocar is currently an anesthesiologist-intensivist at Boston Medical Center (BMC) where he serves as director of both the Anesthesiology Residency Program and the Clinical Simulation Center. An associate professor of anesthesiology at Boston University School of Medicine, Dr. Azocar is also director of the East Newton Campus Surgical Intensive Care Unit at BMC.

His career at BMC has been characterized by a well-rounded combination of clinical care, education, scholarly activities, and advocacy work. Dr. Azocar's clinical interests include the management of trauma victims and the critically ill. He divides his time between the operating room and the Surgical ICU.

As an educator, Dr. Azocar has devoted himself to the education of residents and medical students. As residency program director he introduced innovative ideas and refined the curriculum which led to the ACGME granting a five year accreditation to BMC's Anesthesiology Residency Program. Dr. Azocar directs



*Ruben J. Azocar, M.D.
MSA President-Elect*

an active simulation center which is not only accessible to anesthesiology residents but also to other Departments. Recently, Dr. Azocar obtained a grant from the American Geriatric Society to develop a Geriatric Anesthesiology Curriculum. Dr. Azocar has been awarded

BMC Anesthesia Department's Best Teacher Golden Apple Award (2001), the Ellison Pierce Award in Education and Patient Safety (2005, 2009, 2010), and a Teaching Recognition Honorable Mention by the International Anesthesia Research Society in 2004.

Dr. Azocar has written a variety of book chapters on critical care medicine topics, including analgesia and sedation in the ICU and critical care management during natural disasters. He was a co-author in a recent article in Critical Care Medicine where he described the incidence and implications of delirium in the surgical critically ill patient. He has lectured nationally and internationally. Notably, Dr. Azocar co-directed a simulation workshop at the World Congress of Anesthesiology in Cape Town, South Africa in 2008.

Dr. Azocar serves as a member of the Society of Critical Care Subcommittee on Fundamentals of Disaster Management and he was recently appointed to the ASA

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MSA President-elect Dr. Ruben Azocar with President Dr. Fred Shapiro

REMINDER TO MEMBERS

IT'S THAT TIME OF YEAR THAT THE IN-COMING PRESIDENT, DR. AZOCAR, WILL BE REVIEWING THE MSA COMMITTEES AND APPOINTING COMMITTEE MEMBERS - IF YOU ARE INTERESTED IN GETTING INVOLVED, PLEASE CONTACT THE MSA OFFICE BEFORE APRIL 1, 2011.

(see page 2 for a listing of MSA Committees)

Report of Counsel - continued

Overview of Governor's Proposal

(continued from page 1)

controls on health care costs and insurance premiums.

I. Overview of Governor's Proposal (H. 1849)

H.1849 is built upon the recommendations of the Special Commission on the Health Care Payment System which 2 years ago recommended that the fee-for-service payment system be replaced by a prospective global payment system built around accountable care organizations (ACOs) consisting of physicians, hospitals and other clinical providers, and such integrated systems should become the predominant form of provider payment in the Commonwealth.

The preamble of H.1849 states that many of the costs and quality problems in health care are either caused or exacerbated by the current fee-for-service payment system. It further states that the bill is intended to limit health care costs while improving health care services to residents of the Commonwealth by encouraging the formation of integrated care organizations (known as Accountable Care Organizations – "ACOs") and provide for payment methods that will decrease total per capita expenditures and rate of growth and expenditures for health care, and improve the efficiency, effectiveness and quality of the Commonwealth's health care delivery system.

1. Insurance Commissioner's Authority to Oversee Insurance Rate Increases.

The bill prohibits an insurance carrier from contracting or renewing a contract with any health care provider in which increases in the rate of reimbursement for the provider exceeds an amount established by the Insurance Commissioner. **Effectively, this is an indirect state imposed cap on health care provider reimbursement.** Each year the Commissioner would set by regulation that amount and would consider the following factors in setting the maximum amount of



Edward J. Brennan, Jr.
MSA Legal Counsel

increase in the rate of reimbursements:

- the rate of increase in the state's Gross Domestic Product;
- the rate of increase in total medical expenses in the region as reported by the Division of Health Care Finance and Policy;
- a provider's rate of reimbursement for the insurance carrier, especially in relation to the carrier's state wide average relative price;
- whether the insurance carrier and the contracting provider are transforming from a fee-for-service contract to an alternative payment contract;
- such other factors that the Commissioner may prescribe by regulation

To the extent provider rates decline or increases are contained, insurance carriers are required to factor such savings into premiums charged to consumers.

2. Accountable Care Organizations (ACOs).

Unlike the recommendation of the Special Commission on the Health Care Payment System, the Governor's bill does not mandate a state-wide conversion of the health care payment system to a global payment system, but the bill does encourage the formation of ACOs by mandating standardized criteria for ACOs:

- requires ACOs to be certified or licensed by the Division of Health Care Finance and Policy (DHCFP) with financial oversight by the Division of Insurance and directs the DHCFP to standardize alternative payment methodologies;
- aims to expand use of alternative payment methods and significantly reduce fee-for-service payments by the end of 2015. An alternative payment method includes shared savings components, bundle payments, episode based payments and global payments as defined by state regulation. Alternative payment methods can not be fee-for-service based.

An ACO is defined as "an entity comprised of provider groups which operates as a single integrated organization that accepts at least shared responsibility for the cost and primary responsibility for the quality of care delivered to a specific population of patients cared for by the group's clinicians; which operates consistent with principals of a patient centered medical home and satisfies the other requirements of law; which has a formal legal structure to receive and distribute savings; and which complies with any federal requirement applicable to ACOs, however named, which have been or may be enacted or adopted in law or regulation."

The bill does not address how physicians will interact within ACOs other than a requirement that primary care physicians can only participate in one ACO. No such restriction is placed on specialists, such as anesthesiologists.

A Payment Reform Coordination Council consisting of state officials would be created to oversee the transition to a global payment system. It would establish a plan of action, timelines, benchmarks and standards to facilitate the establishment of ACOs throughout the state by June, 2015. The Council's role is to make recommendations to government agencies overseeing payment reform. The Council

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DIRECTOR'S REPORT

ASA DIRECTOR'S REPORT 2011 - March 2011

It is my pleasure to give you my first report as Director from Massachusetts to the ASA. Dr. Michael Entrup, our previous Director, has moved out of state and we wish him well in his new endeavors. What does your Director do for you, the members of MSA? I represent your interests at the ASA Board of Directors and in the House of Delegates, so that Massachusetts' concerns are part of ASA activity. I also provide a national perspective and advice to the rest of the MSA leadership.

ASA has been active in the past year on several fronts to serve its members. ASA continues to lobby and advocate for a permanent fix to the Sustainable Growth Rate (SGR)-mandated cuts in physician payments. In addition, ASA worked to raise the profile of the provider "non-discrimination" provisions of PPACA at the 2010 AMA House of Delegates meeting and gained approval of a resolution calling on the AMA to seek repeal of those provisions. ASA's advocacy on this issue led to introduction of the Healthcare Truth & Transparency legislation, which was not enacted in the 2010 legislative session but will be raised again.



Beverly K. Philip, M.D.
ASA Director

ASA has been active on the regulatory front as well. The Centers for Medicare and Medicaid Services (CMS) has issued revised Interpretive Guidelines (IGs) pertaining to its Conditions of Participation for hospitals and ambulatory surgery centers twice recently. After the December 2009 IGs were released, ASA members, leadership, and the ASA Regulatory team

focused on three areas to alleviate members' concerns with the new regulations: the labor epidural supervision exemption for nurses, pre-anesthesia requirements, and post-anesthesia requirements. In the new 2011 IGs, ASA secured significant changes that benefit ASA members on each of these topics; the labor analgesia exemption has been removed and pre- and post-anesthesia requirements are more in line with clinical practice. Many of the changes included language provided by ASA. The revised IGs further solidified the role of the one anesthesia service, which has authority over all sedation and anesthesia in a facility and must be led by the physician Director of Anesthesia Services. Our own Alexander Hannenberg, M.D., ASA Immediate Past President, was deeply involved in the regulatory process including meeting with CMS to obtain these changes. Also, an ASA workgroup led by Beverly Philip, MD with members of the Committee on Quality Management and Departmental Administration produced documentation templates and policies to facilitate members' ability to comply with the requirements of the IGs. These are available to be used and adapted, and can be downloaded from the Members Only page of the ASA website.

CMS requires that the single anesthesia service must create institutional standards for all sedation/analgesia, and ASA, listening to requests from members, saw the opportunity to retain leadership of sedation privileging in the interest of patient safety. An ad hoc committee was formed to address this need, led by Beverly Philip, MD, and developed the "Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners", setting high education, training and performance-evaluation criteria for non-anesthesiologist physicians who may potentially qualify for deep sedation privileges. The advisory was approved by the House of Delegates in October. Found at

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Personality Profile-continued

MSA President-elect Dr. Ruben Azocar

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Geriatric Anesthesia Committee. He is an Associate Oral Board Examiner with the American Board of Anesthesiology. From 2007 to 2010 he was the Chair of the MSA programs Committee leading the MSA to implement current ACCME regulations. He has served as an MSA district representative, alternate delegate, and currently delegate to the ASA.

Dr. Azocar has raced in three Boston Marathons, a Chicago marathon and many triathlons. He enjoys outdoors activities with his son Jose, his daughter Andrea and his wife Maray.

There is no doubt that Dr. Azocar's commitment to education, scholarly activities, advocacy and the safe patient care combined with the guidance of the MSA Executive Committee, will assure that our Society continues to represent its members well and that the highest standards in patient care achieved by our specialty are maintained. ~

HOSPITAL IN REVIEW

TUFTS IS THE FASTEST GROWING ACADEMIC MEDICAL CENTER IN NEW ENGLAND

by Scott Segal, M.D.

It has been 33 years since Tufts was last featured in these pages. In the third of a century since, Tufts Medical Center and the Department of Anesthesiology have seen transformative growth and advancement. New buildings, a new provider network, new missions, and a new name are just a few of the developments that have propelled Tufts into the forefront of the Boston academic medical landscape.

The institution now occupying a campus in the Chinatown neighborhood of Boston got its start well over two hundred years ago. Prominent early American patriots, including Paul Revere and Samuel Adams, founded the Boston Dispensary in 1796 to serve the medical needs of the poor. Predating many of Boston's other prestigious academic hospitals, the Dispensary was noted for many firsts during the century after its founding, including the first medical clinic, dental clinic, lung clinic, evening pay clinic, well-child clinic, preventative health clinic, and food and nutrition clinic in the region or country. In 1894, a leased hospital ship began operating as the Floating Hospital for Children in Boston Harbor, providing a respite from squalid urban life and offering fresh air and medical attention to children. The Floating was credited with establishment of a human milk bank and the first successful cows' milk-based infant formula, still sold today as Similac®. In 1929, the Dispensary, the Floating Hospital (then operating on land), and Tufts College Medical School united to form the New England Medical Center (NEMC). A diagnostic facility, the Pratt Clinic, was opened in 1931 and became the nation's largest diagnostic hospital by 1938. In 1949 it also joined NEMC as the New England Center Hospital and was by that time a full service general hospital. To reflect strengthening academic ties to Tufts University, the name was changed to Tufts-New England Medical Center.



*Tufts Medical Center, the Floating Hospital for Children,
800 Washington Street, Boston, MA*

Growth of clinical and research facilities followed over the ensuing decades, including the world's first pediatric trauma center; Neely House, a first of its kind bed-and-breakfast style home for cancer patients and their families; Boston's largest heart transplant program; the establishment of four interdisciplinary research institutes in cardiology, cancer biology, health policy, and mother and infant health; and the Tufts Clinical and Translational Science Institute. The arrival of Ellen Zane as CEO in 2004 heralded a new period of growth for the institution. Borrowing from a decade of experience in network development, the New England Quality Care Alliance, now the second largest physician network in Massachusetts was formed. Working with Tufts University President Larry Bacow, Tufts-NEMC changed its name one final

time in 2008 to Tufts Medical Center, reflecting the continued strengthening of its academic ties.

Today Tufts has 415 licensed beds, including adult and pediatric units, 5 adult ICUs, a pediatric ICU, a neonatal ICU, a full-service obstetric unit, and an inpatient psychiatric unit. It provides care to over 21,000 inpatients, 41,000 emergency department patients, and approximately 14,000 surgical patients in 23 operating rooms each year. Tufts is the fastest growing academic medical center in New England. It is also one of the lowest cost providers in Boston. Most importantly, it is the only academic medical center in New England on the University Health Consortium Top Ten list for quality and safety. All of these accomplishments
(continued on next page)

Hospital in review - continued

Tufts Department of Anesthesiology is comprised of 33 faculty attending anesthesiologists, 24 residents, 4 fellows (2 cardiothoracic and 2 pediatric), 1 nurse anesthetist, and 3-6 student nurse anesthetists.

(continued from previous page)

continue to recognize Tufts' dramatic growth and its commitment to quality care.

The Department of Anesthesiology has also grown and evolved in parallel with Tufts Medical Center. In 1949, Benjamin Etsten MD, whose lineage traces back to the very initial branches of anesthesia chairpersons planted by Ralph Waters, became its first chairperson. He established not only an independent clinical service, but a residency program, and research laboratory specializing in the effects of anesthetics on the myocardium. In 1974, Dr. Kurt Schmidt, the first of noted physicians recruited from across town at Brigham and Women's Hospital, became its second chairperson. Dr. Schmidt was responsible for the transitioning of a small department working in the basement of the Farnsworth Building to the new operating room complex that crosses Washington Street.

Dr. Heinrich Wurm had been instrumental in all facets of the clinical missions of the Department and became Chair in 1991. He oversaw a great expansion of the Department's missions during his more than 15 years as Chair that included the introduction of an active obstetric unit, cardiac and pediatric fellowships, a dedicated ambulatory surgical center, outstanding acute and chronic pain services, solid organ transplantation and the expansion of anesthesia services in the operating rooms and beyond, including interventional radiology and neurosurgery, adult and pediatric cardiac catheterization laboratory, electrophysiology laboratory, electroconvulsive therapy procedures, pediatric imaging, and endoscopy.

The residency program gradually increased in size as well, from 15 in the 1970's to 24 today. Tufts Medical Center has also been engaged in the training of nurse anesthetists for nearly 50 years and



All faculty are appointed at Tufts University School of Medicine and are Diplomates of the American Board of Anesthesiology.

is very proud of the outstanding caregivers that we graduate, and their integration into the anesthesia care teams throughout New England and beyond. Michael Entrup, MD assumed the chair in 2007 but left to pursue other career opportunities a year later. In the summer of 2010, Scott Segal, MD, MHCM became Chair following a nationwide search. He had previously been Vice Chair for Education at Brigham and Women's Hospital, where he had trained 20 years earlier. He brings experience in obstetric anesthesia,

residency and fellowship education, a long history of clinical research, and formal health-care management training to the job.

Today, the Tufts Department of Anesthesiology is comprised of 33 faculty attending anesthesiologists, 24 residents, 4 fellows (2 cardiothoracic and 2 pediatric), 1 nurse anesthetist, and 3-6 student nurse anesthetists. Support staff include seven business and administrative positions, three research administrators, and eight anesthesia technicians. Third and fourth-year medical students from Tufts University School of Medicine rotate through the department

monthly, and rotators from the Departments of Surgery and Oral Surgery, as well as students from the Tufts University School of Dental Medicine spend time with the department throughout the year.

All faculty are appointed at Tufts University School of Medicine and are Diplomates of the American Board of Anesthesiology. The vast majority is fellowship trained in one or more specialties. They are active in hospital

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COMMITTEE ON PROGRAMS

ANOTHER SUCCESSFUL YEAR OF CONTINUING MEDICAL EDUCATION PROGRAMS - March 2011

2009-2011
Chair



Cristin A. McMurray, M.D.

The Program Committee of the MSA was pleased to help organize and support a number of programs in 2010. We initiated an extremely well attended Ultrasound-guided Regional Anesthesia workshop in the spring. The course offered practical didactics as well as hands-on exposure with live models in small groups; we were fortunate to be able to draw upon a number of skilled and advanced local practitioners to run and teach at the course. Due to the high demand, we repeated the course in the fall as well.

The Fourth Annual New England Anesthesia Resident Conference was held

in April at Boston Medical Center. The conference, run by residents in programs throughout New England, featured presentations by residents as well as a career panel focused on exploring options for job selection; Alex Hannenberg, MD, the then-president of the ASA gave the keynote lecture.

We also continued the Annual Sedation and Analgesia Conference in May, designed primarily for non-anesthesiologists providing sedation. The 53rd Annual New England Society of Anesthesiologists Annual Fall Conference was held in Newcastle, NH in September, with excellent attendance and a wide variety of topics covered; these included pediatric perioperative pain, neuromonitoring, and

medical disaster relief missions. The MSA has been a joint sponsor of this program for a number of years.

We held our First Annual Winter Conference in Puerto Rico in January. The committee decided that a new approach to a "tropical destination" meeting was needed, and the program featured a number of excellent presenters from our state. The program was a resounding success. We are also pleased to be offering the First Annual Difficult Airway Workshop in March. Please look for our flyers in the mail and check out the website for upcoming programs. As always, we are excited to hear from the members of the MSA for suggestions for program topics or other ideas. ~



Dr. Mehio explaining a block at the Ultrasound course in November, 2010



Pictured above; Program Director, Dr. Ruben Azocar with presenters Drs. Keith Lewis, Alexander Hannenberg, Stephen Heard and Sheila Ryan Barnett. A breathtaking backdrop for the First Annual Winter Meeting in San Juan, Puerto Rico.

REPORT OF THE ECONOMICS COMMITTEE

LABOR EPIDURALS AND TUFTS HEALTH PLAN - March 2011

2008-2012
Chair



Alexander A. Hannenberg, M.D.

Over the past year, MSA members have reported that sporadic audits and recoupment requests have been undertaken by Tufts Health Plan. In these activities, the Plan indicates its belief that they have had a recognized policy of reporting only time in direct contact with the patient for labor epidural services. The audit seeks to recover payments for time units other than those documented as “face to face” time.

In June of 1999, Tufts circulated a “tips and guidelines” document that laid out a detailed illustration of reporting face-time for labor epidurals. Then, as now, this approach was unprecedented in the region. At the time, I wrote to Tufts to state that we would have a very difficult time implementing time reporting under different conventions for each of the plans and asked that Tufts revert to the standard “insertion through delivery” time with a ceiling on the total time units recognized. Shortly thereafter, a Tufts medical director replied in agreement and indicated that we should revert to “insertion through delivery” reporting. All subsequent documents from Tufts emphasized the time unit ceilings and never since the retracted 1999 bulletin has Tufts published anything vaguely resembling the 1999 effort to explain “cumulated time for redosing” appeared. Indeed, in 2003, Tufts itself characterized the “face to face” time methodology as “onerous and unworkable” and reiterated the expectation that we would report time

using the “insertion through delivery” standard, with a time unit ceiling. (Many will recall that Tufts claims systems were incapable of implementing the unit ceiling for several years despite their repeated emphasis on the policy).

My report in the MSA Newsletter (Winter 1999) included the following:

TUFTS HEALTH PLAN

In early August, anesthesiologists participating in the Tufts Health Plan received a bulletin titled “Anesthesia Billing Tips and Guidelines” which addressed many anesthesia-specific billing issues. The item which received the most response from MSA members was a discussion of time reporting for epidural labor analgesia. The Tufts document indicated that only time spent dosing or assessing an epidural could be accumulated and reported for billing purposes. Many anesthesiologists pointed out to Tufts (and to MSA) that this was a radical departure from generally accepted practice and would have a major impact on reimbursement for this important service. I have had several discussions with senior Tufts staff on this subject and have been told that they intended no policy change, would reconsider the issue and that we “need do nothing different.” I hope that MSA will be involved in developing a clarification of the policy statement on this and several other ambiguous items in the Tufts bulletin.

Tufts asserts that their instructions pertaining to surgical anesthesia (“time not in personal attendance is not reportable”) applies equally to obstetrical anesthesia, and that providers should have inferred that face-time was their standard in addition to the time unit ceilings. This is in direct conflict with the ASA Relative Value Guide that states “unlike operative

anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services.” The RVG goes on to cite four methods for reporting labor analgesia including:

- “Base units plus time units (insertion through delivery) subject to a reasonable cap”
- “Base units plus one unit per hour for neuraxial anesthesia management plus direct patient contact time (insertion, management of adverse events, delivery, removal).”

Notably, the policy that Tufts purports to have had in place, i.e., patient contact time subject to a cap, is inconsistent with any of the standard methods recognized in the Relative Value Guide.

Representatives from Tufts made presentations to MSA conferences in 2003 and 2007. The handouts of those presentations are in the possession of many members. While both speakers discussed labor epidurals, in neither case was any mention of face-to-face time included in the Tufts comments. In 1999, I had made clear to Tufts that such a policy represented a “significant departure” from long-standing practice. A reasonable person would expect such a change to be communicated clearly. Nowhere in a decade’s worth of bulletins from Tufts does the expression “change in policy” or “effective date” appear in this context. With this in mind, it’s not surprising that an MSA survey of Massachusetts departments in early 2010 failed to identify a single department that reported face-to-face time to any health plan or payer. These findings would seem to answer the question of whether Tufts effectively communicated a change in policy at any time over the preceding decade. ~

Hospital in Review - continued

Tufts has plans to expand the Pain Management Center

(continued from page 9)

committees, including the chair of the sedation oversight committee, vice chair of the IRB, elected membership on the Medical Board, and membership on the trauma, pharmacy and therapeutics, CPR, safety, patient care assessment, research steering, surgical executive, OR management, ethics, graduate medical education, and medical school admissions committees. Three are involved with the ABA certification process for the written or oral examination. Tufts Medical Center serves as the academic home of the Tufts University School of Medicine Department of Anesthesiology as well. In this role, Dr. Segal serves as the academic Chair for Tufts affiliates, including St. Elizabeth's Medical Center in Brighton, Baystate Medical Center in Springfield, and Maine Medical Center in Portland, ME. Each affiliate manages its own clinical operations independently but academic appointments and promotions are centralized.

Tufts anesthesia residents hail from top medical schools across the nation and selected international locations. In addition to completing rotations in all aspects of anesthesiology care, 100% are given research experience during dedicated rotations, and they are offered electives in advanced practice (including international health, advanced pain management, advanced obstetric anesthesia, and echocardiography). Many pursue fellowship training following residency and numerous graduates have joined the faculty at Tufts and other prestigious academic programs around the country, and some of the best private practices.

Tufts Medical Center boasts a particularly collaborative academic environment. Collaborations of a clinical, educational, and research character are widespread and growing. The Department of Anesthesiology has research collaborations with numerous other Tufts



Today Tufts has 415 licensed beds, including adult and pediatric units, 5 adult ICUs, a pediatric ICU, a neonatal ICU, a full-service obstetric unit, and an inpatient psychiatric unit.

Medical Center clinical departments, with TUSM basic and clinical science departments, with the TUSM Clinical Skills and Simulation Center (in addition to its own departmental simulator), with the Tufts University campus in Medford, and with faculty from the School of Dental Medicine and the Boston Nutrition and Obesity Research Center. These diverse relationships are driving the expansion of the department's research efforts, including a record number of grant applications in the past year.

In the coming year, the department has plans to expand the Pain Management Center, overhaul the Preoperative Assessment Clinic, introduce software-based preoperative screening, install a state-of-the-art Anesthesia Information Management System (AIMS) in the OR's, and introduce anesthesiology intensivists in the surgical intensive care unit. We will see expansion of the clinical mission with

an aggressive plan to grow the pediatric cardiac surgery program, expand the robotic surgery program, and build a hybrid cardiology-cardiac surgery OR. A new neuroscience ICU will open this spring, and a state-of-the-art pediatric sedation center funded by a grant from the Ronald McDonald foundation will open later this year.

Our mission, however, is unchanged: to be a premier academic department of anesthesiology, providing clinical excellence supported and enhanced by a foundation of evidence-based clinical and basic research and a commitment to teaching at all levels. As Tufts Medical Center has evolved over its over 200-year history, and the department over its more than half-century, we have strived to maintain and expand the collaborative spirit and tradition of expertise and excellence that characterizes this storied institution. ~

[Director's report - continued](#)**The need for strong ASA action on both legislative and regulatory fronts will continue, and ASA needs your support***(continued from page 7)*

<http://asahq.org/For-Members/Clinical-Information/Standards-Guidelines-and-Statements.aspx>, it can be used in its entirety, in part, or adapted as needed, to represent the Anesthesiology viewpoint on deep sedation privileging in your facility.

On yet another front, we have all experienced the dramatic and unpredictable shortages of many of our critical drugs. There are many reasons for this increase in shortages, and to find out more about this vexing problem go to <http://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Drug-Shortages.aspx>. ASA co-convoked a Drug Shortages Summit on November 5, 2010, which resulted in the introduction of the "Preserving Access to Life-Saving Medications Act". ASA is actively working with the FDA, the American Society of Health System Pharmacists and other groups to reduce the frequency of these shortages.

The 2010 ASA Meeting in New Orleans was a resounding success. The educational and scientific portions of the meeting were strong. Other highlights of the 2010 meeting were a Member reception in PETCO stadium, included in the registration fee, and a stirring presentation



Pictured above; Dr. Philip with President Dr. Fred Shapiro and Dr. Mary Ann Vann, both from Beth Israel Deaconess Medical Center

by the copilot of the "in the Hudson" US Airways flight 1529. Such member events will be continued in future meetings. Plan now to attend ASA 2011 in Chicago!

The need for strong ASA action on both legislative and regulatory fronts will continue, and ASA needs your support. We all benefit from ASA's efforts. Every anesthesiologist should contribute to ASAPAC to support this critical work.

Also, recruit your anesthesiologist colleagues to join MSA and ASA if they are not yet members – and we invite you to become more active yourself.

I am excited to serve you in this new capacity as your Director to the ASA Board of Directors. If you have any questions or comments, or needs that could be addressed, please do contact me. ~

LEGISLATIVE CONFERENCE 2011**J.W. Marriott Hotel, Washington, D.C.****MAY 2 - 4, 2011****visit www.asahq.org for more information**

Report of Counsel - continued

(continued from page 6)

would be advised by an 18 member committee, appointed by the Governor, consisting of state officials, representatives of insurers, hospitals, physicians (2 primary care, 2 specialists), employers, unions and consumers. Health care providers would be in the minority.

3. Medical Malpractice Reform.

The Governor's legislation also reforms the medical malpractice liability system to emphasize prompt resolution, deemphasize "defensive medicine", reduce the number of costly lawsuits and improve care. The bill specifically:

- establishes a 180-day cooling off period before a party may initiate suit;
- creates a process for providers and aggrieved patients to communicate and exchange documents prior to litigation in the hope that more open communication by both parties will resolve disputes;
- makes a provider's apology inadmissible in evidence;
- amends the peer review laws to include ACOs.

H. 1849 has been assigned to the Committee on Health Care Financing for a hearing and consideration.

II. Nurse Anesthetist Prescription Authority

The Board of Registration in Nursing and the Drug Control Program within the Department of Public Health are in the process of promulgating regulations implementing the new law that allows CRNAs the authority to issue written prescriptions and order tests and therapeutics under the supervision of a physician only for the immediate perioperative care of a patient. The law defines "immediate perioperative care" as commencing on the day prior to surgery and ending upon discharge from post-anesthesia care. The administration of anesthesia by a CRNA to a patient does not require a prescription. The MSA submitted testimony at a hearing in January proposing clarifications to the proposed regulations.

Once the regulations are promulgated, CRNAs, who wish to prescribe, will

be eligible to obtain DEA numbers and register with the Drug Control Program at DPH. It is important to note the law requires that the prescribing of medications and ordering of tests and therapeutics during the immediate perioperative care of a patient must be addressed in guidelines mutually developed and agreed upon by the nurse and supervising physician. Those guidelines must be consistent with the regulations of the Nursing Board and the Board of Registration in Medicine. Current guidelines regarding the administration of anesthesia will need to be amended to be in compliance with the new law, should the CRNA and supervising physician agree that the CRNA will have prescriptive authority.

When the Nursing Board and DPH promulgate their regulations, MSA will post on its website a link to the new regulations as well as a link to the regulations of the Board of Registration in Medicine governing the responsibilities of the supervising physician. ~

MSA BYLAWS COMMITTEE REPORT - March 2011

Chair
2010-2011



Lee S. Perrin, MD,

Your Committee on Bylaws has been very busy this past year. You will receive the full report in time to vote on it at the Annual Meeting in May, but first it needs approval by the Executive Committee.

Last year the ASA changed its definition of who can be a member of a component society to allow those state components to permit membership by where you work or where you live. Prior to this, MSA has had

the requirement that you must have your practice principally in Massachusetts. The Executive Committee is considering submitting an amendment that will allow membership based on your principal professional activity or residence in Massachusetts.

Similarly, a change in the bylaw determining to which District a member belongs to allow the member to choose between where they work or live will be debated.

The Executive Committee also is considering deleting the requirement for endorsement by two active members as part of the application and approval process.

The other section debated at the March 23 Executive Committee meeting was the requirements for election as an officer of the MSA. Currently, a candidate needs to be an active member of the MSA for two years and a voting member of the ASA for five years prior to being elected. The term

"voting member" has been interpreted to mean ASA Active member, as active members are the only members eligible to vote. One proposal is to delete "voting" from the bylaw. This would allow time spent as a resident, fellow or medical student to count toward the five years. Another proposal is to allow only those members who have their place of principal professional activity in Massachusetts be eligible to be an officer.

Several items were approved at the January 27 meeting of the Executive Committee. These included a clarification of the function of ex-officio committee members and the addition of the President-Elect and Vice President to the Committee on Headquarters Office Oversight.

Watch your mailboxes for the ballots for officers and the notice of the Annual Meeting where these bylaw changes will be voted upon. ~



During October 2010, history enthusiasts from Boston area teaching hospitals formed the Boston Anesthesia History Group. The primary reason for joining forces and working together was the recognition that collective action was necessary to promote the study of history.

The group is not affiliated with any particular Department, Hospital, Medical School, University, or Professional Organization. Members do not pay dues and the group does not maintain a bank account or undertake financial dealings. Founding members were selected on the basis of an interest in history, and they represent anesthesia departments from each of the four medical schools in Massachusetts.

We seek to promote history by supporting and undertaking the following activities.

- Conduct history related tours in New England.
- Organize and participate in meetings and conferences related to history.
- Perform research related to history.
- Publish scholarly work related to history in bulletins, peer-reviewed medical journals, magazines, and books.
- Develop a curriculum for the teaching of history of anesthesia inside and outside the classroom.
- Provide mentorship to individuals who wish to embark on projects related to history.
- Be a resource for information and visiting lecturers.

Founder: *Sukumar P. Desai, M.D.*
Department of Anesthesiology, Perioperative and Pain Medicine,
Brigham and Women's Hospital, Harvard Medical School, Boston

Alphabetical list of founding members:

Fred G. Davis, M.D., Department of Anesthesiology, Tufts Medical Center,
Boston.

Manisha S. Desai, M.D., Department of Anesthesiology, UMass Memorial Health
Care, Worcester.

Elliott V. Miller, M.D., [Retired] Department of Anesthesia and Critical Care
Medicine, Massachusetts General Hospital, Harvard Medical School, Boston.

Rafael A. Ortega, M.D., Department of Anesthesiology, Boston Medical Center,
Boston.

Joan E. Spiegel, M.D., Department of Anesthesia, Critical Care and Pain
Medicine, Beth Israel Deaconess Medical Center, Harvard Medical School,
Boston.

Susan A. Vassallo, M.D., Department of Anesthesia, Critical Care and Pain
Medicine, Massachusetts General Hospital, Harvard Medical School, Boston.

David B. Waisel, M.D., Department of Anesthesia, Children's Hospital Boston,
Harvard Medical School, Boston.

Individuals interested in learning more about our activities and publications, or wishing to get in touch with founding members are requested to contact Sukumar P. Desai, M.D. electronically at sdesai@partners.org



Anesthesia History - continued

(continued from page 1)

stone cutter from Thebes is the first Egyptian mummy to be brought to the US, and was gifted to the MGH in 1823 by Dutch merchant Jacob Van Lennep. This 2500 year old mummy was in attendance during the ether demonstration and remains there today. Also present is a marble statue of Apollo, son of Zeus, and father of Asclepius [Greek God of Medicine]. It was sculpted in Paris, and was a gift from Edward Everett, the grand orator who spoke for 2 hours at the dedication of the National Cemetery at Gettysburg, just before President Abraham Lincoln's famous 2 minute address. Everett served as congressman and senator from Massachusetts, as well as President of Harvard University, and the town of Everett, Massachusetts is named after him. Since electricity was not available in 1846, the operation was performed in the morning, illuminated only by natural light. The dome's generous window-panes provide evidence of the thoughtfulness of Charles Bullfinch, the first American born and trained professional architect. Visiting today, one can stand in the Ether Dome feasting eyes on many of the same artifacts that decorated the dome in 1846. If one chooses to climb the steep stairs, and take a seat where many of the great minds in medicine have been one is automatically drawn to a stunning painting that consumes the back wall. This work by Warren and Lucia Prosperi, commissioned for the 150th anniversary celebration of the original event, recreates the drama of October 16, 1846. Physicians and individuals related to MGH were photographed in period costumes, and the artists used these images to recreate a most realistic scene. Surgical instruments of that era are displayed in a showcase, and a small museum with memorabilia surrounds the outside of the Ether Dome. As one exits the Bullfinch building one should examine remnants of a pier on the outside of the hospital. Much of the land we see around MGH is a result of landmaking and city expansion over water. In 1846, patients often arrived at this waterfront hospital by horse carriage, or by boat.



John A. Fox, M.D. [Anesthesiologist, Brigham and Women's Hospital] describing various aspects of the Ether Monument during a 2010 tour for residents of his department. Under his left arm is a copy of Rafael A. Ortega's book, 'Written in Granite: An Illustrated History of the Ether Monument.'

The Ether Monument: Erected in 1868, ironically the year of Morton's unexpected death, and located within the Boston Public Gardens, the first public botanical garden in the US, the Ether Monument was donated to the city of Boston by Thomas Lee, a prominent merchant. This magnificent granite structure is full of allegorical representations that include a statue of the Good Samaritan at its apex, and scenes depicting various aspects of science and medical care on its four sides. It was Boston physician and poet Oliver Wendell Holmes who suggested the term anesthesia in a letter to Morton. He wryly remarked that the monument be called the 'Ether Monument,' confirming that claims for the discovery of anesthesia had remained unresolved. Rafael A. Ortega, M.D., a historian and anesthesiologist at the Boston Medical Center, published a

book about this famous granite structure in 2006 [*Written in Granite: An Illustrated History of the Ether Monument*; Publisher, Plexus Management, Boston].

Mount Auburn Cemetery: Horticulturist and physician Jacob Bigelow chanced to visit Père-Lachaise Cemetery during a trip to Paris. Burial practices in America and most of Europe were quite squalid in the early 19th century. Limited space in municipal burial lots and church yards led to stacking, subsequent removal of remains, foraging by animals, or worse. Bigelow recreated the concept of the European landscaped garden cemetery when he founded Mount Auburn Cemetery in 1831. A place for meditation and reminiscence, this was the first such cemetery in the country, and is the final resting place for many of the participants of the ether demonstration, including William Thomas Green Morton, as well as his principal opponent, Charles Thomas Jackson. For decades, it was a must-see destination for visitors to Boston. Its name derives from Oliver Goldsmith's poem, 'The Deserted Village.'

Morton Homes: Morton was born in Charlton, Massachusetts in 1819, and spent his childhood and youth in homes that were made memorable by a series of water color paintings by Leroy D. Vandam, M.D., Chief of Anesthesia at Peter Bent Brigham for over three decades. Two of the homes are private residences, while the third, a barn in which the Morton family carried out a business in farm equipment, is dilapidated. After gaining prominence in the late 1840s, Morton moved to a 50-acre estate called *Etherton* in Wellesley [then West Needham]. The property was later acquired by businessman Horation Hunnewell, who in turn donated the land and bore costs for the construction, in 1886, of what is currently Wellesley Town Hall. The town separated from West Needham in 1881, and adopted the name Wellesley in honor of Hunnewell's wife, whose

(continued on next page)

Anesthesia History - continued

(continued from previous page)

maiden name was Welles. Reminders of Morton exist on a plaque outside the building, and an adjacent field and street are named after him.

The Francis A. Countway Library of Medicine was founded in 1960 as a result of the union of Harvard Medical School Library and Boston Medical Library. Located on the premises of Harvard Medical School, it is also home to the Center for the History of Medicine, and the Warren Anatomical Museum, named after John Collins Warren, founder of MGH, and the surgeon who performed the operation on October 16, 1846. Warren donated his own body to this museum that contains over 15,000 artifacts. Included are several ether flasks, the original instruments used during the operation, a death-mask of Horace Wells, portraits of several of the participants of the ether demonstration, and original specimens of anesthesia records introduced by medical students Harvey Cushing and Ernest Amory Codman. Perhaps the item of most interest to anesthesia historians is Robert C. Hinckley's painting, 'The First Operation Under Ether.' Completed a half century after the event, Hinckley found it difficult to sell the painting and almost destroyed it, before it was acquired by the Boston Medical Library. Ignored at the outset, it has become one of the most famous paintings depicting a scene related to the history of medicine. ~



Manisha S. Desai, M.D. [Anesthesiologist, UMass Memorial Health Care] at Morton's birthplace in Charlton during a 2010 tour for residents of her Department. Shown with her, at the right, are the current owners of the property. A plaque near the door reads – Birthplace of William Thomas Green Morton (1819–1868) who first publicly demonstrated ether anesthesia, October 16th, 1846, erected by the American Society of Anesthetists, Inc. [sic] May 6th, 1941.



Drs. Alex Hannenberg, Sukran Sahin, current president of the Turkish Society of Anesthesiologists, and William Camann. Dr. Hannenberg and Dr. Camann were speakers at the Turkish Society of Anesthesiologists annual meeting in Antalya, Turkey, October 27-30. October 29th is "Republic Day" in Turkey, the day they celebrate the founding of the nation, similar to our July 4th.

ASA NEWS

**POLITICAL ADVOCACY IS NOT FREE.....
DONATE TO YOUR ASA-PAC TODAY!!**

by Donald G. Ganim, II, M.D.

The ASA's political action committee (PAC) was formed in 1991 as a bi-partisan, non-ideological political voice of ALL anesthesiologists. Its defined mission statement is simply to "advance the goals of the medical specialty of anesthesiology through the bipartisan support of candidates who demonstrate their commitment to patient safety and quality of care."

ASA-PAC supports candidates for federal and local offices and lobbys on behalf of the anesthesia profession. As the largest medical specialty PAC, the ASA-PAC plays a key role in determining how much we are paid, the regulatory and legal environment in which we practice, and the role of non-physician providers in our practices. The PAC allows us to influence the political decisions that directly impact our practices. The PAC provides anesthesiologists access to legislators both

in Washington and at their local district offices.

Federal and state laws prohibit associations, like the ASA, from involving itself directly in the political process. Only PAC's can participate. Anesthesiologists make donations to their PAC because they recognize the challenges that our profession faces: attacks on physician-led anesthesia, underfunded Medicare payments for anesthesia services, and a burdensome regulatory and legal environment.

Anesthesiologists who donate to their PAC understand that political involvement is CRITICAL to meeting the challenges to our profession.

Like the AANA or the AAJ's advocacy for CRNA's and lawyers, the ASA-PAC funds newspaper advertisements, radio spots and direct mail campaigns during political elections to carry anesthesiology's message to voters.



Donald G. Ganim, II, M.D.

Do NOT stand idle and allow your colleagues to make contributions on your behalf. Call Tracy at the Park Ridge office 1-847-825-5586 or go on the ASA web site and make your 2011 donation today.~

ONE MEMORABLE MSA DINNER . . .

by Gerald Zeitlin, M.D.

In the early 1970's the M.S.A. held a monthly dinner on Friday evenings from September to May with a brief business meeting followed by a lecture of scientific interest. In those days there were not to many academic meetings held in San Diego or Sun Valley. These meetings were for the whole membership - perhaps 150 of us altogether in those days.

On this particular winter Friday evening we were gathered at Pier Four on Boston's harbor. Just as we had sat down to choose between scrumptious scrod or chirping chicken the President (I forget who it was but he or she should hereby identify themselves) announced that the lecturer, Dr. Herbert Benson of



Gerald L. Zeitlin, M.D.

hypnosis fame, was coming from out of town to talk to us but had been delayed by about an hour due to a snowstorm.

We took our time with the dinner and eventually Dr. Benson arrived. He quickly got to the meat of his talk - a demonstration of mass hypnosis. It was a sight to behold as he had us wave a finger in front of our noses as we all chanted, in unison "One, two, one, two and so on." Heads usually devoted to vigilance in the operating room nodded and sank on chests and Dr. Benson proudly proclaimed: "There you are you doubting anesthesiologists. It works!"

What he did not know was that when our beloved President announced Dr. Benson's delay he also announced that the Pier Four management had agreed to keep the bar open while we waited. ~

Quod Erat Demonstrandum

ASA NEWS**UPDATE ON THE ANESTHESIA QUALITY INSTITUTE**

The Anesthesia Quality Institute (AQI) was founded in 2009 by ASA to be the profession's voice for quality management. To accomplish this, AQI is developing the National Anesthesia Clinical Outcomes Registry (NACOR), now in its second year of operation. As of December 1, 2010, NACOR contained data from 34 anesthesia practices, representing 24 states, 1800 anesthesia providers, and 170 facilities. Case-specific data is available from 21 practices, and will include more than 500,000 cases for 2010.

Participation in NACOR is open to any anesthesia practice in the United States, regardless of their current use of information technology. The cost of participation is minimal, and is sharply discounted for ASA members. NACOR works by capturing reports from existing digital systems, including billing software, anesthesia information management systems, quality management programs and hospital information technology. The AQI works closely with both the practice and their software vendors to generate a flow of data that will not interfere with the daily activities of busy practitioners. All anesthesiologists are going to feel increasing pressure to examine and improve their outcomes. The AQI is committed to easing this process, so that clinicians can concentrate on what they do best.

Practices participating in NACOR



Richard P. Dutton, M.D.

receive quarterly benchmarking reports from the AQI. These begin with simple 'snapshot' looks at important practice metrics: number of cases done, distribution of services, duration of cases, and the like. Each metric is presented in the context of national benchmarks, so the practice can compare their performance with their peers. This is done at both the practice and the facility level, so the group can understand, for example, how the average duration of a cataract extraction at their Surgicenter compares with similar groups and locations nationwide. In 2011 the practice will be able to interact directly with the AQI report server, to directly examine their data 'cube' for the variables of greatest interest. This will include the ability to examine outcomes—like the rate of nausea and vomiting after

ambulatory surgery—at both the group and the individual provider level. We believe this kind of private, confidential reporting of local data and national benchmarks will give the practice a powerful tool to improve patient outcomes and business efficiency.

Aggregated data from NACOR, de-identified as to location, practice and providers, will be reported to ASA leadership on a regular basis, to provide objective information for advocacy with payors and regulators. De-identified data from NACOR will be available for academics, and will be especially useful in support of 'comparative effectiveness' projects that seek to examine outcomes from real-world clinical practice. In addition to supporting these efforts, the AQI plans two new ventures in 2011: establishment of pain management data entry software that supports long-term monitoring of patient outcomes, and creation of a nationwide mechanism for reporting 'near-misses:' the Anesthesia Incident Reporting System (AIRS). AIRS will be a secure system to capture detailed information on the cases of greatest interest, and allow for ground level analysis to complement the top-down approach of NACOR.

AQI is constantly building on the data we already have by signing on new participants. Please visit our Web site at www.aqihq.org to learn more about participation or send any questions to askaqi@asahq.org.

The NACOR initiative will help ASA to secure our profession's well-deserved reputation as the leader in patient safety.~

ASA Annual Meeting
October 15 - 19, 2011
New England Caucus Meetings
Saturday 3:00 - 5:00 pm • Tuesday 4:00 - 6:00 pm
Chicago, IL

WHY CAN'T I SAVE ENOUGH TO RETIRE THE WAY I WANT?

by Dan Heitzman,
CFP®, ChFC, CLU, MBA, AIF®

Doctors like many people are looking forward to retirement with increasing concern about what their retirement will look like. In many cases, the retirement they are looking at is not the one they had envisioned when they started out in medicine. Yes, doctors are amongst the highest earning professions in the country and certainly many doctors count themselves as millionaires. So why are so many doctors not as comfortable heading into retirement as they should be based on their incomes?

According to Thomas J. Stanley, PHD, the author of the best selling book *The Millionaire Next Door*, doctors define wealth differently from many people. For many doctors, wealth equals having a high income. Ignoring the philosophical discussion about what being "wealthy" means, from a financial perspective, true wealth means not having to go to work in the morning if you don't want to. It is money making money... and generating a large enough income stream to cover all of your lifestyle needs. According to Stanley, doctors are prodigious under accumulators of wealth based on the amount of income they earn. True wealth is based on assets, not income.

And why is confusing income with true wealth important? It is important because the government taxes income, it does not tax net worth or wealth. The true measure of one's wealth is net worth. And just like doctors advise people to have a physical each year to monitor their physical health, doctors should measure their net worth each year to monitor their financial health. Ask yourself the question "Who is wealthier, the person who makes and spends \$500,000/year or the person who makes \$500,000, lives on \$200,000

and invests the remainder, so that \$10,000 of unearned income is generated each year. Not too surprisingly, wealth is a result of hard work, perseverance and discipline. And although many doctors certainly have the first two traits, it is less clear, relative to other professions, that doctors are disciplined towards building wealth which can create the retirement they are seeking.

As a group, business owners are the largest accumulators of financial wealth based on their income. A primary reason for this is that they are focused on attaining a financial goal. As true capitalists they are willing to sacrifice immediate gratification for future success by re-investing in their business. Yes, doctors make financial sacrifices while in med school and while doing their residency, but they also graduate with larger amounts of debt than their non-doctor classmates. Once in practice, doctors are soon earning very high incomes relative to their non-doctor classmates but unlike many business owners, they spend more of what they earn. Good wealth builders learn to live below their means while they are saving for the future. Because doctors start saving later, and start with a high debt level, they need to save even more. Consider this: a person who wants to live on \$200,000/year, excluding social security, beginning at age 65, will need to save \$5 Million dollars. A 25 year old can attain this by saving \$11,296 per year. A doctor who waits 10 more years until age 35 to begin saving will need to put aside \$30,396 a year. As Einstein said, the greatest discovery of mankind is not relativity, it is compound interest.

So what steps can one take to correct this situation? First, start with the recognition that you need a financial goal. How much money will you need to have at age X to generate Y dollars a year for

the rest of your life? A rule of thumb is that at age 65 you will need one million dollars for every \$40,000 of income that is needed.

Second, use the results of the latest research in behavioral finance to understand the basic principals which cause people to financially self-destruct. As the cartoon character, Pogo, aptly stated "we have met the enemy and he is us". In particular, be aware that our brains are hard-wired for investment failure. There now exists academic research that explains why investors routinely buy high and sell low. Herd behavior, loss aversion, media response bias and optimism and over-confidence, are basic human behavioral characteristics that work against building a solid financial future. Finally, Socrates said that wisdom is demonstrated by those who know what they do not know. No doubt, you have had a conversation with a patient who has proudly shared with you the fact they were recently awarded an MD degree from Google University. Patiently you have listened to them while they questioned a diagnosis or a recommendation. To help you reach your retirement goals, find a financial advisor that you can trust, and use them to improve your financial health the way you help people with their physical health. ~

The author is a Registered Representative and Investment Adviser Representative with/and offers Securities and Advisory Services through Commonwealth Financial Network, Member of FINRA/SIPC, a Registered Investment Adviser. www.stonebridgefc.com

Disclaimer: the Author is not affiliated with the MSA and all opinions expressed are his own and not of the MSA.

MSA ANNUAL REPORTS 2009 - 2010

MSA ANNUAL MEETING SECRETARY'S REPORT - MAY 26, 2010

Secretary
2009-2011



Selina A. Long, M.D.

The Active membership of the Massachusetts Society of Anesthesiologists has surpassed the 900 mark, the present count is 918 active members. This entitles the MSA to ten (10) ASA Delegates at the ASA House of Delegates, October 16-20, 2010, in San Diego, CA; this is an increase of one delegate over prior years.

The MSA membership drive is ongoing. If you are aware of any potential members, please encourage them to join and bring their names to the attention of the membership department.

Membership totals as of May 26, 2010

Active 918
Affiliate 18
Resident 417
Retired 170

In Memoriam

Martha Boyd, MD	VA
Francis Callahan, MD	Worcester, MA
Franco Dinale, MD	CT
Robert M. Smith, MD	
Sarita Walzer, MD	Newton, MA

2010 MSA District Elections

District Representative	Alternate District Rep.
District 1 Mark Vanden Bosch, MD	David L. Pomerantz, MD
District 2 Spiro G. Spanakis, DO	Bronwyn Cooper, MD
District 3 Donald G. Ganim, II, MD	Charles C. Ho, MD
District 4 Ben Kaon, MD	(vacant at this time)
District 5 David G. Garrett, MD	Susan R. Lisman, MD
District 6 Cristin McMurray, MD	Vladimir V. Kazakin, MD

Results of the 2010 Election (152 ballots returned)

President	Fred E. Shapiro, DO
President-Elect	Ruben J. Azocar, MD
Vice President	Jesse Ehrenfeld, MD (position currently vacant)

Treasurer (2 year term)
Daniel J.P. O'Brien, MD

ASA Delegates (2010-2013) (3 year term)

Ruben J. Azocar, MD
Beverly K. Philip, MD
Sheila Ryan Barnett, MD
Fred E. Shapiro, DO

Alternate Delegates (1 year term)

Fred G. Davis, MD	Jesse M. Ehrenfeld, MD
Michael R. England, MD	Stephen L. Hatch, MD
Mark D. Hershey, MD	Vladimir V. Kazakin, MD
Cristin A. McMurray, MD	Timothy S. Pederson, MD
Spiro G. Spanakis, DO	Joshua C. Vacanti, MD

The Following Officers will continue

Secretary Selina A. Long, MD (2011)

ASA Director (3 year term)

Michael H. Entrup, MD

ASA Alternate Director (3 year term)

Beverly K. Philip, MD

ASA Delegates

McCallum R. Hoyt, MD, MBA (2011)
Daniel J.P. O'Brien, MD (2011)
Lee S. Perrin, MD (2011)
David L. Hepner, MD (2012)
Selina A. Long, MD (2012)
Richard D. Urman, MD, MBA (2012)

MSA Annual Reports - continued**OUTGOING PRESIDENT'S REPORT, MAY 21, 2010**

President
(2009-2010)



David L. Hepner, MD

Annual Meeting Minutes, 2010
Report of the President

Dr. Hepner introduced Dr. Mark Warner, ASA President-Elect. Dr. Hepner summarized the very eventful year during his presidency. He noted:

1. Successful negotiation of legislation giving CRNAs limited prescriptive authority. Nurse Anesthetists are the only APNs without prescriptive authority. The MSA negotiated a compromised bill with the Chairman of the Public Health Committee that would give CRNAs authority to issue written prescriptions and order tests and therapeutics under the supervision of a physician only for the immediate peri-operative care of a patient (commencing on the day prior to surgery and ending upon discharge from post-anesthesia care). He noted that originally the nurse anesthetists had filed a bill three years ago that would have granted them broad authority to prescribe and function without physician supervision. The bill is currently before the House of Representatives and is expected to pass.
2. **Payment Reform:** Dr. Hepner reported on efforts on Beacon Hill to scrap the current fee-for-service reimbursement system used by all payors for a global payment model built around Accountable Care Organizations (ACOs) consisting of hospitals, physicians and other clinical

providers. The MSA (Dr. Hannenberg) testified at a legislative hearing in October cautioning against an across the board imposition of global payments. The legislature has put off consideration of payment reform until the next legislative session. Dr. Hepner testified at another legislative hearing in November in opposition to a bill that would reduce health insurance premiums for small businesses by setting physician and hospital fees at 110% of Medicare and forcing providers to accept the fee as a condition of licensure. The bill was referred to the House Committee on Ways and Means where it is expected to die.

Dr. Hepner saluted Dr. Alex Hannenberg, President of ASA, for his strong advocacy for anesthesiology at the national and state levels. Dr. Hepner reported on the very successful reception in New Orleans last October sponsored by MSA and ASA for Dr. Hannenberg upon his

ascension to ASA President. Dr. Hepner noted that the MSA sponsored a reception here in Massachusetts for Dr. Hannenberg at the Woodland Country Club in Newton, which was a great success. Dr. Hepner thanked MSA members who contributed to the success of the receptions and Dr. Mark Hershey for organizing the event in Massachusetts.

Dr. Hepner reminded those present to visit the ASA PAC booth and make contributions for this year. He noted the importance for anesthesiologists to be active politically at the national and state levels.

Dr. Hepner advised members to read the various committee reports in the distributed handout. He thanked the members of the Executive Committee for their support as well as Beth Arnold, Barbara Kenealy and Ed Brennan. He wished Dr. Shapiro much success in his tenure as President. ~



Outgoing MSA president Dr. David Hepner conversing with incoming president Dr. Fred Shapiro at the 2010 Annual Meeting at MIT Endicott House, Dedham

MSA Annual Reports - continued**ASA DIRECTOR'S REPORT, MAY 2010**

(Former)
ASA Director
2009-2011



Michael H. Entrup, M.D.

With the change in policy makers after the last national election, there is a renewed effort and we are likely to see major reform in our healthcare system with *an emphasis on providing health care to all, increasing value, yet at the same time decreasing costs.*"

That's from my Director's Report to the 2009 MSA Annual Meeting. With the election of Scott Brown to The United States Senate, who would have predicted that a major healthcare reform bill(s) would pass in 2010? But it did. Several provisions in the bill, including the lack of a permanent fix to the SGR formula and the creation of the unelected and unaccountable Independent Payment Advisory Boards (IPABs), have major implications for our specialty and our ability to care for our patients. While the bill did not specifically address the issue of Medicare payment disparity for anesthesia services, it did provide for the Secretary of HHS to review and possibly correct mis-valued and potentially under-valued services. This was a major focus of discussion during our congressional visits on Capital Hill last month at the ASA Legislative Conference. Twenty-one MSA members and residents, including ASA President Alex Hannenberg and Legal Counsel/Lobbyist Ed Brennan, attended the Conference and made Hill visits to each and

every one of our Congressperson's and Senator's offices. In addition to ensuring fair payment for anesthesia services, we also addressed the Health Care Truth and Transparency Act and rural pass-through to expand patient access to physician anesthesiology services in rural areas.

As you are aware, there have been many personnel, structural, and procedural changes within ASA to make our organization more efficient and effective in improving care and advocating for our patients and the 40,000 plus members of ASA. The rapid pace and outcome of health reform legislation raised several issues/concerns for the BOD. These included the perception that AMA did not support ASA member needs in healthcare reform and the role of the ASA BOD in the decision-making process of ASA. Alex, as we've come to expect, did a terrific job in addressing these issues by creating a BOD listserv and setting up several town hall meeting style teleconferences to keep us informed and involved, rather than waiting for the next BOD or HOD meeting. ASA has joined a coalition

of 16 surgical subspecialty groups with common issues and concerns regarding the healthcare reform. The recent posting by the ABA regarding the potential revocation of board certification for any diplomate participating in the lethal injection process has raised quite a bit of discussion through the listserv and during our last teleconference. This will be addressed at the August BOD meeting.

ASA continues its efforts at improving patient care while advocating for our patients and our members. Several major undertakings continue towards these goals. The Anesthesia Quality Institute is now established, has a physician Executive Director, and is beginning to sign on groups for submission of data that will be used for benchmarking, research, and assisting members with MOCA requirements. The ASA Branding Campaign has entered a new phase of rollout with the implementation of several creative projects as well as a long-awaited revamping of ASA's web page, which will be unveiled at the Annual Meeting in San

(continued on page 26)



MSA Delegation at the ASA Legislation Conference in May, 2010, at the J.W. Marriott Hotel in Washington D.C.

MSA Annual Reports - continued**REPORT OF THE COMMITTEE ON ECONOMICS, May 2010**

*Chair
2008-2012*



Alexander A. Hannenberg, M.D.

The Committee sponsored a seminar on Practice Management in November. This was ably chaired by Dr. Larry Robbins and featured an excellent and high profile presenters. We continue to seek the optimal scheduling of this conference to make it appealing to physicians and practice administrators alike.

MSA conducted a survey of officers and members to assess the prevailing practices with respect to reporting time units for labor analgesia services. One of the major health plans in the region initiated chart audits in several practices with the assertion that standard practice limited time unit reporting to time of direct patient contact (“face to face” time). No respondents to the MSA survey indicated that this was their understanding or practice.

As payment reform initiatives have taken shape in the Massachusetts legislature, we participated in a round table of hospital based specialties convened by the Massachusetts Medical Society. There were multiple areas of common interest and concern and there is an expectation that this group would continue to confer and strategize.

The committee reviewed a new medical necessity policy issued by Blue Cross-Blue Shield of Massachusetts addressing Monitored Anesthesia Care for gastrointestinal endoscopy. The policy indicates that this service is not universally considered medically necessary but that a wide range of co-existing conditions would justify the service. We indicated to BCBSMA that the MSA is available to confer on such policies in the development stage and objected to the release of the policy only at the time it became effective. Doing so limited the ability of anesthesia and GI practices to adapt their practice patterns to conform. This policy is not dissimilar to multiple such policies in place with other carriers around the country. ~

* * * * *

REPORT OF THE PUBLIC EDUCATION COMMITTEE - May 2010

*Chair
2008-2011*



Fred E. Shapiro, D.O.

Many thanks to the doctors that volunteered and took the time from their busy schedules to visit the schools and educate the students about the importance of the anesthesiologist

Recently Dr. Cally Hoyt, Director of Gynecologic and Ambulatory Anesthesia at BWH lectured and gave a tour of the Longwood Medical Area to the Boston Latin students

The Massachusetts Society of anesthesiologists will continue along with national effort to inform our anesthesia community about the benefits of supporting the ASA Political Activities Committee (ASA-PAC). This enables a ‘voice of support’ which has crucial impact on current national legislative issues: health care reform, ceasing Medicare payment cuts, truth and transparency bill and extending rural pass-through payments to anesthesiologists. The success of the Teaching Rule legislation is a testimony to how information, persistence, and visibility of our profession can make a difference.

The newly revised MSA Website will enable three MSA Committee to merge their efforts and creativity The Public Education committee will join the Committees on Publication and Website in a combined effort with Drs Urman and Spanakis to design a section that will specifically address the educational opportunities MSA can provide for the public. They are in the process of developing a link on the site for the public to submit inquiries about our profession.

Dr. Shapiro has been a member of the Executive Board and Chairman, Public Education Committee since 2001 and in May 2010, became President of the Massachusetts Society of Anesthesiologists.~

*MSA Annual Reports - continued***MSA PROGRAM COMMITTEE - May 2010**

*Chair
2008-2010*



Ruben J. Azocar, M.D.

The MSA Programs Committee had a busy yet very rewarding year.

We successfully achieved a four year accreditation by the Massachusetts Medical Society to continue providing CME credits. However, during the preparation for the site visit and after reviewing the citations received, the Committee took action to assure that compliance with the newest ACCME regulations is achieved. The Committee instituted changes in the planning of our conferences as well as in

the evaluation forms. Additionally, we will work closely with the MMS to clarify the differences between commercial support and exhibit fees and establish clear rules for the participation of the industry in our educational venues.

In terms of conferences, the MSA organized two conferences in the Fall of 2009 and two in the Spring of 2010. In the Fall we had the Annual Bermuda conference that was moderated by Dr. Mark Hershey and the Practice Management Meeting organized by Dr. Larry Robbins. In the Spring, the first Ultrasound-guided regional anesthesia course took place. It was an instant success. This meeting was Co-Chaired by Drs. Cristin McMurray, Abdel Mehio and Arnel Almeda. In May the Annual Sedation and Analgesia meeting had for venue the University of Massachusetts Medical Center this year. Drs. Shubjeet Kaur and Manisha Desai co-chaired this effort to educate non-anesthesiologists providing sedation and analgesia.

Additionally, the committee jointly sponsored the always successful and excellently organized annual NESAs meeting, in September of 2009. The New England Anesthesiology Resident Conference, hosted by the Department of Anesthesiology at Boston Medical Center / Boston University School of Medicine was also jointly sponsored by the MSA.

It should be mentioned that the committee also made a difficult decision to change the time and venue of our Annual Fall Conference after holding it in Bermuda for many years. In January of 2011 the Annual Conference will take place in San Juan, Puerto Rico over the Martin Luther King weekend. An excellent program and a fascinating location are being secured for this conference.

Finally, this May, my term as Chair for this Committee ceases and Dr. Cristin McMurray will assume this role for the next two years. I wish her the best of luck and my unrestricted support in this endeavor. ~

**CHECK THE MSA WEBSITE FOR THE NEXT MSA
ULTRASOUND-GUIDED REGIONAL ANESTHESIA WORKSHOP
TENTATIVELY SCHEDULED FOR FALL 2011**



Pictured above; Dr. Fred Shapiro with incoming program committee chair, Dr. Cristin McMurray and Dr. Brett Simon, Chair, BIDMC.

MSA Annual Reports - continued**MSA COMMITTEE ON RESIDENT AFFAIRS, May 2010**

Kenneth Johnson, M.D.

This year, the Committee on Residents Affairs (CORA) was more active than ever. Our Executive Committee was extraordinarily productive and sponsored a number of educational and social events throughout the year, including the New England Anesthesia Residents Conference (NEARC) and the Annual Post-Boards Party. We also contributed to the formation of the MSA's new website.

With the help of the MSA, nine residents and one medical student were able to attend the ASA Annual Meeting in New Orleans as delegates. In addition, three residents were able to take part in the ASA Legislative Conference in Washington, D.C. this past April. Both meetings proved excellent opportunities to gain better understanding of issues in our specialty, and learn ways in which to help solidify a successful future for anesthesiology as a whole. Furthermore, CORA made it our goal to increase resident awareness of and contributions to the ASA-PAC, with the lofty goal of attaining 100% involvement of Massachusetts residents during the upcoming year. This prerogative will be carried forth by the newly elected members of CORA.

Last year CORA made notable achievements in establishing Anesthesiology Interest Groups at all four Massachusetts Medical Schools. This year, we continued to solidify these groups and to cultivate stronger interest in anesthesiol-

ogy amongst medical students during their preclinical years. Sponsored activities included organized shadowing experiences with practicing anesthesiologists in clinical settings and exposure to the procedural aspects of our specialty via simulation centers.

We recently undertook our annual nominating process for next year's officers (2010-2011) and are pleased to announce the results:

Olof Viktorsdotti, MD, MGH

Mark Hoeft, MD, MGH

CORA Co-Chairs

Kenneth Johnson, MD, UMass

Past Chair

C. Ariel Nason, MD, BU

Secretary

Chien-Hsiang Chow, MD, St. Elizabeths

Treasurer

Gassan Chaiban, DO, UMass

Social Chair

Joyce Lo, MD, Brigham & Women's

Social Chair

Satrajit Bose, MD, MHS, St. Elizabeths

Health Policy Coordinator

Maksim Zayaruzny, MD

CORA Advisor, UMass

New England Anesthesia Resident Conference (NEARC)

April 2, 2011

Beth Israel Deaconess Medical Center

<http://fs19.formsite.com/NEARC-2011/registration/>

ASA Director's Report-continued

(continued from page 23)

Diego. Speaking of the Annual Meeting, our Organizational Improvement Initiative established better accounting principles which surprisingly revealed that the Annual Meeting was much more costly than previously thought. As a result, and in an effort to build a much more robust organization, there will be a registration fee for all those attending the Annual Meeting. This will be reviewed with the appropriate committees and ASA leadership. ASA has also entered the third and final year of funding a multi-institutional study on cerebral function monitors.

Other advocacy activities of note

are interactions with CMS regarding our concerns and issues with their recent interpretive guidelines and addressing medication error prevention in neuroaxial block and infection control of endotracheal intubation in response to The Joint Commission.

I hope, from this brief update of ASA activities, you recognize the value of your ASA membership. I'm sure Dr. Warner will expand on many of these issues tonight. Remember, **every anesthesiologist benefits from ASA's efforts.** Every anesthesiologist should be a member of ASA and should contribute to ASAPAC to support our legislative/political efforts

on your behalf. As a component, MSA member contributions to ASAPAC, once again, continues to fair poorly compared to other components. Each of us knows members of our respective departments who are not members of MSA, ASA, or ASAPAC. Please join with us in the challenge to get them involved.

Again, it's been an honor and pleasure to serve as your Director to the ASA Board of Directors. I thank the Executive Committee and MSA members for all of your help, support, and confidence in this position. ~

MSA Annual Reports - continued**A SUMMARY OF ASA PRESIDENT DR. MARK WARNER'S UPDATE AT THE MSA ANNUAL MEETING, 2010***by Kenneth Johnson, MD*

At the annual meeting on May 27th, 2010, the Massachusetts Society of Anesthesiologists had the honor of hosting Dr. Mark Warner, current president of the American Society of Anesthesiologists, as its guest speaker. Dr. Warner delivered a clear and concise, yet thought-provoking speech regarding the past, present and future of our society and our specialty. The following is a summary of the key points that he raised and his thoughts on how we can successfully move forward together as a group of physicians.

Dr. Warner began his speech with the ASA's mission statement: to advance the practice and secure the future for anesthesiologists. The ASA is a member-organization, with the ultimate goal of working for that membership. Much akin to leaving a legacy for one's family, the ASA must focus its actions towards the next generation of physicians. In the past few years, the ASA has taken a group historically weak in this regard and helped gain considerable strength. Anesthesiologists have become more recognized and respected as experts in all aspects of perioperative medicine, and that hospital administrators continue to take notice of it. As hospitals focus more on efficiency and cost-containment in the operating room setting, they will rely on the valuable input of anesthesiologists in making these important decisions. But this is only the tip of the proverbial iceberg....he followed this with four pertinent questions that need to be addressed:

1. Are we advocating for fair and reasonable compensation to provide resources necessary for advances in science and basic care?

The year 2008 was a great year for anesthesiology as a specialty: the 18-month extension of the SGR, SQRI bonus payments adjustment, and passage of the teaching rule. In 2009, we successfully



Pictured above with ASA guest speaker, Dr. Warner, MSA members Drs. Urman, Shapiro, Hannenberg, and Perrin

challenged the issue of "hand offs", thanks in part to the dedicated work of Dr. Alex Hannenberg. Now in 2010 health care reform looms large. And while a lot of things are still unclear as to its full impact, there are several glaring omissions from the bill. These include a long-term fix of the SGR, a solution to anesthesiology's "33% problem," the need for expansion of access (a "rural pass-through), and better truth and transparency within a rapidly broadening medical field. These are all issues that need to be solved in the coming months and years. Thanks in part to the ASA-PAC and people at the ASA office working through social networking and Internet search engines, these issues are being made known to the general public. Of note, the ASA-PAC is now the biggest physician PAC in the country (including the AMA-PAC), with over 3,500 donors and over \$2 million dollars raised... and it does have a real impact!

2. How is anesthesiology holding together as a specialty?

Currently, 72% of practicing anesthesiologists belong to the ASA. While this is above the median as far as other

subspecialty groups, the question remains "why only 72%?" It is safe to say it is probably not a monetary issue. The more likely situation is that anesthesiologists do not feel the need or responsibility to join. Therefore, the ASA plans to increase enrollment by demonstrating its importance and usefulness: better advocacy, better educational activities, and better tools to maintain certification in anesthesiology. In addition, the Anesthesia Quality Institute, will eventually help lead to practice improvements and increased patient safety. It is the hope that the ASA can eventually obtain 90+% enrollment as these improvements manifest themselves to the younger generation of anesthesiologists.

3. How well are we training the next generation?

There is a concern that the specialty of anesthesiology is not attracting the very best medical student candidates possible. How can we attract a greater percentage of the "best and brightest"? It is important to excite medical students about our specialty through early

(continued on next page)

MSA Annual Reports - continued

COMMITTEE ON PUBLICATIONS - May 2010

by Richard D. Urman, M.D., MBA
Chair 2009-2012

1. The latest edition of the MSA Record was published in April and mailed to the entire membership. The plan is to publish it once a year, in the spring. We encourage contributions by our membership.
2. The new website is up and running (www.massanesthesiology.org). The project is being spearheaded by Dr. Spiro Spanakis, Chair of the Website Sub-committee. He and the rest of the sub-committee members deserve a lot of credit for coming up with the website content and overall design. Any feedback about the new website should be addressed to Dr. Spanakis as he continues to work with the MCD Studios on perfecting it.

3. The Publications committee addressed the usage of MSA membership database (emails, mailing addresses) by outside parties. The issue was brought up for discussion

in the spring. No specific decision has been made by the Executive committee, and discussion will resume in the fall. ~



(Pictured above; Dr. Dan O'Brien, ASA President-elect Dr. Mark Warner and Dr. Richard Urman.)

Summary of ASA President Dr. Warner's Update-continued

(continued from page 27)

exposure and interest. An example of this would be through active involvement and cooperation with anesthesiology interest groups at medical schools. Anesthesiology has the widest scope of any medical practice, with care ranging from the youngest to the oldest of patients. It involves managing both chronic and acute disease processes, while requiring a mastery of a broad range of pharmacology and physiology. Medical students need to be made better aware of the excitement that the practice of anesthesiology entails... for until this happens, our specialty will not reach its true potential for growth and greatness.

4. Have we encouraged new knowledge to make our specialty safer?

The ASA wants to expand interest

in research. The problem begins with the fact that only 8% of the annual ASA budget supports our research-oriented foundations (Foundation for Anesthesia Education and Research (FAER) grant, Wood Library-Museum, Anesthesia Patient Safety Foundation (APSF)). However, the problem runs much deeper. The simple fact is that there is a very low percentage of young anesthesiologists pursuing scientific advancement. Out of twenty-four medical specialties, anesthesiology is number 23 in receiving federal funding from foundations such as the NIH. Yet the specialty has the same success rate in receiving funding as any other specialty (including internal medicine and orthopedics). It is simply the unfortunate truth that applications are not being submitted; there are not enough men and women in anesthesiology who

want to compete. How will the next quantum leap in anesthesia be made if no one is doing the research to discover it? Unless this changes, the future of our specialty looks rather dim.

In his final thoughts of the evening, Dr. Warner emphasized one major point: he urged ASA members to help make our society better. This could be through involvement at either state or national levels. Write a newsletter article or letter-to-the-editor. Advocate for our specialty and for those issues most important to our future. Talk to the next generation: students in high school, college, or medical school. Get them interested and excited about anesthesiology, because without them we have no future. Everyone needs to do his or her part... because we are all in this together. ~

MEMBERSHIP CHANGES 3/10 - 3/11**New Active**

Peter Anderson, MD, Guardian Anes
 Michael Andrawes, MD, MGH
 Nicole Arboleda, MD, Bwh
 Sascha S. Beutler, MD, BWH
 Sarah Blake, MD, Guardian
 Jessica Bland, MD, Baystate MC
 Amil Bogdanov, MD, Tufts MC
 Carl Borromeo, MD, Lahey Clinic
 Kristine Boulanger, MD, BWH
 Sebastian Bourgeois, MD, Baystate MC
 Peter Calkin, MD, Guardian Anes
 Toni Chahla, MD, Baystate MC
 Jamie May-Lynn Cheung, MD, BWH
 Tomas Cvrk, MD, Lahey Clinic
 Galina Davidyuk, MD, BWH
 Rebecca DeCampli, MD, Berkshire MC
 Christopher Dow, MD, Baystate MC
 Nasser El-Mallah, MD, Mercy Hosp.
 Jason Erlich, MD, So. Shore Hosp.
 Oleg Evgenov, MD, MGH
 Eddy Feliz, MD, AAM
 Peter Fischer, MD, BWH
 Russell Flatto, MD, UMass
 Sridhar Ganda, MD, Holy Family
 Lauren Gavin, MD, BWH
 Meera Grover, MD, BWH
 Carlos Guzman, MD, AAM
 Brian Hashim, MD, BIDMC
 Behzad Hejazian, MD, Tufts, MC
 Jan Hilberath, MD, BWH
 Humayon Khan, MD, Brockton Hosp.
 Sonia Kapoor, MD, Tufts MC
 Suzanne Klainer, MD, BWH
 Timothy Kubicki, MD, AAM
 Robert Lekowski, MD, BWG
 Albert Lim, DO, Baystate Med. Ctr
 Gustavo Lozada, MD, Tufts MC
 Christine Mai, MD, MGH
 Angelina Mavropoulos, MD, BWH
 Jennifer McSweeney, MD, BWG
 Akmal Mikhail, MD, Norwood Hosp.
 Noila Moghul, MD, BWH
 Charles Nyman, MD, BWH
 Nam Hoon Park, MD, Holy Family
 Dilip Patel, MD, Winchester Hospital
 Deborah Pederson, MD, MGH
 Sadeq Ali Quraishi, MD, MGH
 Jay Sarma, MD, MGH

Anthony Schwergerl, MD, UMass
 Guy Sciortino, MD, Lahey Clinic
 Stacie Noble Shriver, MD, Martha's V.
 Daryl Smith, MD, Baystate Med. Ctr
 Robert Stephenson, MD, St. Elizabeth's MC
 Jason Stewart, MD, BWH
 Andrew Sukiennik, MD, Winchester Hosp.
 Coral Sun, MD, Brockton Hosp.
 Hariharan Sundram, MD, St. Elizabeth's MC
 Shanthan Sunku, MD, Baystate MC
 Gary Thal, MD, Vertex Pharm
 Dirk Varelman, MD, BWH
 Carmelita Wallace, MD, BWH
 David Whiting, MD, CHMC
 Karin Zuegge, MD, Baystate Med. Ctr

Active, Moved Out of State

Meraj Mohiuddin, MD, MO

Retired

Gilbert Connelly, MD, W. Yarmouth
 Ammani Dasari, MD, Lexington
 Stephen Hall, MD, So. Hadley
 William Henderson, MD, Shrewsbury
 Arpa Mahasaen, MD, So. Natick

Deceased

Leonard S. Bushnell, MD, NH
 William Cummings, MD, So. Hadley
 Enzo Fruggiero, MD,

BOX SCORE	
Membership Totals (03/11)	
Active	924
Resident	455
Affiliate	14
Retired	171



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